Working Group to Reinvent Medicaid
Meeting #2
Monday April 6, 2015
4:00pm – 6:00pm
Department of Administration
Conference Room A &B

I. Welcome:
   a. Dr. Wilson, Co-Chair, welcomes the members, reminds the group what has been done this past month and half. Town Hall meetings, internal discussions, emails back and forth with staff.
   b. Dennis Keefe, Co-Chair, joins Dr. Wilson in welcoming the members. Mr. Keefe reiterates that a great deal of work has been done thus far, and that four work stream groups have been meeting to try to focus on key issues surrounding high utilizer populations, long term care populations, populations impacted by behavioral and mental health issues, as well as work on delivery system reforms. He advises that we will hear a bit about the work those groups have been undertaking over the course of this meeting.
   c. Health and Human Services Secretary Roberts thanks the Co-Chairs for opening the meeting and for their work. She advises that she would like to introduce the first speaker of the day, John Simmons with RIPEC, who is here to give an update and provide an understanding of how the business community views Medicaid, how Medicaid impacts the business community, and the RI economic climate.

II. Medicaid from the Business Perspective – John Simmons, Executive Director, RIPEC
   a. Presentation slides available on reinventingmedicaid.ri.gov
   b. Questions:
      i. Patrick Quinn: On your state projections how much of that is state dollars, how much is federal dollars? Have you taken into account that other states have county taxes?
         1. John Simmons: Those are actually state projections, and they are tied together. This is both combined.
      ii. Linda Katz: Not surprisingly the Economic Progress Institute has a different perspective. The RIte Care program and the RIte Share program have businesses that show their employees benefit, which in turn benefits the companies. There was a Senate report to show how many employees are benefiting from state health benefits; an important thing to put on the table.

III. Innovations Under Way
   a. Timothy Babineau, MD with Lifespan: I do not have any slides today, but would like to present on the work we are doing at Lifespan. When

thinking about delivery system reform at Life years ago we had a few key principles that we aimed to adhere to. Whatever we decided to do had to cut across all payers. And though we are here focused on Medicaid, it is important to remember patients are patients regardless of who is paying the bills. Also, we wanted to be sure to consider children. And whatever we decided to do, we knew it had to be supported in the short term and also in the long term by work coming down the pike.

We feel strongly that the root cause of most of our delivery system issues stem from fragmentation and lack of coordination of care. Until [you] get at that fundamental issue of how to coordinate care better, one is only nibbling at the edges. Exchanging information is key. For the last eight days I have been hunkered down with staff working on how to coordinate care across [Lifespan's] system, and replace that entire system while still staying in operation. A week ago [Lifespan] flipped the switch and moved to a single, enterprise-wide, electronic health record for any patient who touches the lifespan health care system, using Epic as a platform.

We have invested well over $100 million, but think of it as a key way to bend the cost curve for all patients. The work of the past few years was not flashy, but it was key to begin the hard work. We learn in many systems primary care systems are vital. Innovative things we have been talking about, combining programs around mental health and physical health, like with Hasbro Six; programs around congestive heart failure; new innovative payment models with major payers; ACO with United.

Rather than get tied up in knots over alphabet soup, we believe strongly that the root cause of all this has to be care coordination. We think we can better coordinate care in our system with this new electronic medical records program, but now we can look at how to do this outside Lifespan. Launch has gone very well so far, the Go-live was very successful. All a way of saying we feel strongly that we need to play our role of decreasing fragmentation. A lot of great working going on around this table

i. Senator DiPalma: Can you speak to how the patient saves money on this efficiency?
   Timothy Babineau: All of the patient's information is now in one place regardless of where in the system he/she entered. This results in a huge reduction of duplication of unnecessary testing; care coordination among care givers, for example enabling a primary care provider to have better communication with gastroenterologist, etc. It was an expense, but an investment that we felt we had to make to stay relevant.
ii. Antonio Barajas: Does Epic capture patients outside the Lifespan system accessing their primary care providers?

Timothy Babineau: At this time [a primary care visit outside Lifespan's systems] won't catch on our system, but we will make sure the systems talk to each other – make sure that Coastal physicians can look into the Lifespan window, for example. Through the health information exchange (HIE) and the work Laura Adams is doing at Rhode Island Quality Institute discussion will be held on how to get all onto the same platform.

iii. Maureen Maigret: Is there a Patient Portal for the system?
Timothy Babineau: Yes, so much of this is getting the patient involved in their care. Patients can interact through, MyLifeChart, and several thousand patients have already signed up. Key part of this effort

b. Dennis Keefe, Care NE came forward to give a presentation on Care New England's ACO. The presentation slides are available on the website reinventingmediciaid.ri.gov

i. Sam Salganik: Are the patients notified if they are being attributed to the ACO? And, is there any patient representation on the board?
Dennis Keefe: Yes, and yes.

ii. Elizabeth Lange: These are great system changes, but the original job of a hospital is to see patients, and in many respects hospitals operate with staffing Monday through Friday from nine to five. Are there conversations being held at the hospital level to save money by increasing inpatient care at a high level seven days a week, twenty-four hours a day so patients are not staying too long?
Dennis Keefe: We need to build a system that coordinates care. A lot of the time the issue is that institutional based care is providing the majority of care; people have to think about how they practice, how they behave. Rethink what they learn, how they seek care. These are things that are key in the next few years.

iii. Maureen Maigret: I noticed on one of the slides that you did not include Long Term Care on that list, and I would image that you would want to include that?
Dennis Keefe: Depending on the arrangement, like what we have with Blue Cross Blue Shield of Rhode Island, it would include Long Term Care.

iv. Senator Miller: Two years ago the Senate had a commission on hospital payment systems, several recommendations came out of that commission, including one that would require a movement away from fee for service towards ACOs. At the time it was evident the state didn't need to mandate it because "we were doing it anyways." Do you think the timing now shows that we should mandate it? Do you think in a Medicaid

conversation it should be a Medicaid requirement?
Dennis Keefe: I think it should be part of the conversation, deserves a discussion before coming down one way or another.
Timothy Babineau: I would just add that three years ago [Lifespan] was almost 100% fee for service, and now almost all our contracts have some kind of quality metric. As bad as the fee for service world was, having one foot in each boat is worse, so we are motivated to move towards the new business model. I don't think it needs to be required, because as providers it is bad business to take our time. Have to resist the temptation to come up with a Medicaid solution, a Medicare Solution, a payer solution etc. Need to redesign the solution for everybody. The business model of our system has been built over 70 years, and to turn our back on it in one year would have, in my opinion, significant waste. I would implore us all to not destroy something that took a long time to build – must be thoughtful in this work.

v. Elizabeth Burke Bryant: Thank you, great presentation, and I am pleased to be part of the work stream that you are heading up. There are ACOs in states without well-developed Medicaid managed care, and often Medicaid is lumped together within those ACOs, as all one issue. I encourage us to look at lessons learned, look at ACOs, look at Medicaid managed care. I do have one question – you indicate in your presentation that the insurance business may be thought of as an ACO, what do you mean by that statement?
Dennis Keefe: The more risk you take on the more you start to resemble the characteristics of the insurer. Strategic partnership with the insurers is important.

vi. Senator DiPalma: A question on your numbers in these slides, are these targets that you hit or were they higher or lower than your plans?
Dennis Keefe: Higher, and that includes Medicare Advantage and Medicaid Shared Savings. That is good; the larger number coming out of the gate gives us the ability to manage the population with less risk.

vii. Peter Marino: I think the strategic partnership is key, focus on quality, focus on primary care, managed care has been successful in this state on those issues. Care management is what Neighborhood Health Plan does well, I think that's why the strategic partnership makes sense – without it one could leave behind key systems. We do RIte Care extremely well, managing that population very well.

c. Al Kurose, MD Coastal Medical: Presentation available on reinventingmedicaid.ri.gov.

i. Chuck Jones: Do you see different challenges with your Medicaid population; would you operate your ACO differently if you were looking at just the Medicaid population?
Al Kurose: My wife is a nurse care manager who manages high risk population folks like you speak of, so I am well aware of the challenges facing this group – I would say that you need more of these resources outlined on these last few slides, having at least as developed a system as this to do proactive population management for the Medicaid population.

d. Deidre Gifford, Medicaid Director, EOHHS: presentation available on reinventingmedicaid.ri.gov
    i. No questions at this time from the group.
e. Kathleen Hittner, MD, OHIC: Passing around two handouts to discuss two reform initiatives that may be useful to you as you are thinking about what to do in the future. Handouts available on reinventingmedicaid.ri.gov.
First is Care Transformation Collaborative, or CTC, a reform effort jointly sponsored, by the Office of the Health Insurance Commissioner and the Executive Office of Health and Human Services (EOHHS) under a legislative mandate. Thus far this has been hugely successful, with a current thirty-three practice sites, four hundred and thirty three providers, serving three hundred thirty thousand Rhode Islanders in this project. This has been successful transforming the practices into Medical homes. Important to have multi payers have physicians and what I am observing is that it is equally important to have the team in the room. Nurse Practitioners, other committees have Contract managers, committees to look at quality metrics. Many of these primary care practices are being paid a certain amount other than fee for service. To have more practices that are primary care medical homes (PCMH), those are transformed. Goals are listed on these documents for the future.
Physicians are taking notes on the patient, the teams taking notes; the work does not always happen in the physician's office – we now know we need to look into the world of their patients. The CTC has two community health teams, including professionals who actually go to see the patients in their homes, and actually ensure that the day to day living is thoughtful to the patient's health. The program also underscores the importance of pharmacists in helping to take care of the patients; there is coordination of care on many different levels. Behavioral health is being brought in now, with creation of a new committee to look at integrating behavioral health, substance abuse treatment, etc., into the care of the patient. Now this is all anecdotal: this program is new, but we have already seen a decrease in readmissions. Overall, we have not yet seen a return on investment, overall. I think that is going to take some time – do need to continue to do it to see the benefits in time.

The second document speaks to the Affordability Standards of the Office of the Health Insurance Commissioner. These are standards to improve the health care system's quality, accessibility and affordability by: expanding and enhancing primary care in the state; promoting the spread of value-based payment models; promoting insurer contracting practices that improve quality and affordability; working with other state agencies to affect change. We do this through the rate review process, and through the affordability standards. [Former Commissioner]Chris Koller put these forward, first to increase the primary care spend. We have to support CSI, PCMH project, have to support CurrentCare, and now our goal is to have people using it on the other end. Peter Andruszkiewicz [BCBSRI] has said we have to make CurrentCare indispensable to those who take care of our patients. We are still working on that.
One of the other things was to limit the amount that a hospital's reimbursement could increase each year in their contracts with insurers. I know the hospitals haven't been thrilled with that particular affordability standard but it has been successful. It took a year to look at these standards and review them. We will continue the primary care spend at 10.7% and meanwhile will do a study to see how we compare with the rest of the state. Continue to support the PCMH project and the CTC project. We have 40% of our physicians participating now, which is the easy lift. Now we are getting out there into the smaller practices, and need to figure out a way to integrate these primary care providers into these projects to have uniformity across our state. If we coordinate primary care with all of these patients, we will achieve our goals. We also put a cap on hospital contracting again, as Dennis Keefe calls a glide path, so that in four years, the increase will be no more than the Consumer Price Index. I think we need to aim for a goal, set it out and go for it. Also, putting a cap on increases in ACO contracting, I don't want that to run away either. We did give bigger leeway, will monitor it and deliberate every year. CurrentCare also needs to be emphasized going forward. Committees working to transform care and transforming the payment methodology –want to see it go to 80% of payment systems other than fee for service.

i. Questions:
   Senator DiPalma: On the CTC, doing this for a few years now, is data tracked on a monthly basis?
   Commissioner Hittner: We do quarterly tracking.
   Senator DiPalma: For population health, for PCMH Kids, what are the goals there?
   Commissioner Hittner: This year we want to bring in ten practices. PCMH Kids has been working with people in this room for the past three years but just started with the CTC for a ten-practice pilot.

ii. Dennis Keefe: My comment on the glide path speaks to this idea: when you look at the economy in RI, particularly in RI, jobs are still the number one challenge. Seventy percent of expenses in health care are labor based. The growth of health care expenses is unsustainable, yet the economy is still highly dependent on health care for jobs. I believe that for those reasons we don't want to just flip that switch overnight. The unit prices for healthcare in RI have declined but there are still issues around utilization, around risk contracting and accountable care. I caution though, if changes are made too fast, too quickly we would disrupt the labor market. Hence the concept of the glide path, to allow us to make necessary changes in a thoughtful way.

iii. Patrick Quinn: The glide path is a good concept but core inflation is higher than it has been, and we have trouble controlling cost. Wages have been driven into the ground since 2008; I think we need to talk about where the resources end up. For if Tim Babineau has to make an agreement with where they end up, the CPI concept is manageable and simple, but with the concept of deflation, and I do not think that is sustainable in the long term, as the economy picks up. We saw that with gas prices alone – different challenges based on income level. We need to help our CNAs, our nurses etc., to live in this economy. Nurses that make forty dollars per hour can handle those changes, but minimum wage health care workers cannot.

Commissioner Hittner: You are right, to note it is CPI minus wages and food. We are trying to get waste under control, as responsibly as possible.

IV. Work Streams Update

a. Dr. Wilson invites the chairs of each work stream to give a brief update on the work done in the past week.

b. Maureen Maigret: Chair the works stream on Long Term Care. Our first meeting was a look at some of the data available and we are requesting more data. The second was interesting as Dr. David Gifford who is the Vice President of Quality and Regulatory Affairs at the American Healthcare Association, came to describe two models for value based purchasing specifically in long term care.

c. Maria Montanaro, Director Behavioral Healthcare, Developmental Disabilities and Hospitals: Behavioral Health Work Stream has been working, really looking at three projects within behavioral health. One is special population management for adults living with severe and persistent mental illness (SPMI). Our hope is that by using an integrated dual eligible project and looking at Medicaid, in conversation with the plans, Medicaid would do a redesign of the integrated health home initiative for adults in that population, to

deliver more integrated care. Elements of that, include pricing, and the idea to meet each public provider where they are at. We have community mental health centers on every spectrum of that transformation, from way out in front, to further behind. Second, folks living with a developmental disability, working with many on the redesign on some of the payment elements within the developmental disabilities services issued through BHDDH. As Dr. Kurose said, there needs to be a reinvestment in transformation. Consent decree and move that system towards long term cost reduction. Finally, services by the state managed under BHDDH, including group homes, RICLAS, and hospital systems. Tomorrow BHDDH will start a study with the hospital system with an independent contractor to really get a look at quality work in the system. The design is to see when, and if any, changes to the systems would create better care at a lower cost.

d. Dennis Keefe: The Delivery System Reform Work stream has held two meetings, first being organizational, the second getting into some areas of potential, trying to remind the group that at the end of the day we have to come up with recommendations that have savings attached. I say that as it is easy to can get lost in the debate, which is why we all have been pulled together. There was some discussion of a Medicaid ACO; we think there is some merit to continue that conversation, designing it similar to shared savings plans. Senior Care organizations also came up as a topic of conversation. Additional areas of focus were: coordination of care between populations; value based purchasing; and finally, whether the state should be pursuing a DSRIP waiver, Delivery System Reform Incentive Program, as a means of funding to transform the system.
e. Ira Wilson: Our High utilizer group also met twice. It is clear that about twenty to twenty-five thousand people are responsible for something close to seventy five percent of the cost of the Medicaid program – a fact that is not entirely unique to RI. First, the group is trying to see how those numbers break down, with an understanding that many in this population are in institutional or residential living situations. There is also a small group, a high cost group of mothers and children, something like three hundred and fifty children, who spend a long time in NICU, which could be managed with more pregnancy care. Left with thirteen to fifteen thousand people living in the community, most of whom have a mental health or behavioral health disorder. We are trying to focus on figuring out who they are, and secondly try to understand what current programs in the state will be useful and can be replicated. Also what hasn't been done but should be done for this key population.
f. Secretary Roberts: Great conversation, one thing that is difficult to work through is we have two goals: one is the much less comfortable which is to assist the Governor in meeting a budget target with helpful proposals, look at ways to manage the deficit. We have also gotten

hundreds of proposals from the town halls, from the website, from many sources, that we are reviewing. Not all will work in practice, but we have been looking and considering them all. This is not a ten year project - it's a two to three year project. What has been going on, is consideration that we are taking incredibly complicated cases and addressing vulnerable people in the state and ensuring that whatever we do, we are servicing them with the triple aim in mind. Just remember in three weeks we do not all disappear.

V. Public Comment: No comment was offered from the public.

VI. Adjourn